Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Growth Hormone Pediatric Prior Authorization Request

The Division reviews requests for prior authorization (PA) on the basis of medical necessity only. If the Division approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. The Division will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/dma**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code

GH Pediatric Indications

Indication for growth hormone requested (check one):

☐ Growth hormone deficiency

☐ Growth reduction due to chronic renal failure

☐ Noonan syndrome

☐ Prader Willi syndrome (Provide documentation of genetic testing)

☐ Small for gestational age with failed catch-up by age 2

☐ Turner syndrome (Provide documentation of genetic testing)

☐ Other: _____

Fill in applicable information below for indication and attach supporting documentation (e.g., copies of medical records, office notes, growth charts, diagnostic studies, laboratory tests).

Current height	Current weight	Date

Growth rate in past year cm	Date of GH stimulation tests

Provide type of GH stimulation tests performed and results _____

IGF-I level	Date	Bone age exam results	Date

Any known tumors? ☐ Yes ☐ No

Female patient pregnant? ☐ Yes ☐ No

Provide date of last appointment with endocrinologist

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date